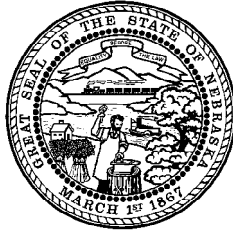


Nebraska Workers' Compensation Court
State Capitol Building
P.O. Box 98908
Lincoln, Nebraska 68509-8908

WHEN COMPLETED, MAIL TO ABOVE ADDRESS



VR-44 (09/04)

VOCATIONAL REHABILITATION PLAN

SOCIAL SECURITY NUMBER:		DATE OF INJURY:		CLAIM NUMBER:	
E M P L O Y E E E	NAME:			I N S U R E R	
	STREET ADDRESS:			COMPANY NAME:	
	CITY, STATE, ZIP CODE:			STREET ADDRESS:	
	PHONE NUMBER:			CITY, STATE, ZIP CODE:	
	DATE OF BIRTH:			CLAIM REPRESENTATIVE:	
EMPLOYER NAME:			EMPLOYER CONTACT PERSON:		PHONE NUMBER:

WAGE INFORMATION:

Pre-Injury Wage: \$ _____ Projected Wage After Rehabilitation: \$ _____

SECTION I - GENERAL PLAN INFORMATION

OCCUPATION AT TIME OF INJURY (INCLUDE D.O.T. CODE):		SELECT THE LOWEST APPLICABLE PRIORITY AVAILABLE TO THIS EMPLOYEE:	
VOCATIONAL REHABILITATION COUNSELOR:		<input type="checkbox"/> RETURN TO THE PREVIOUS JOB WITH THE SAME EMPLOYER	
VOC. REHAB. COUNSELOR'S W.C.C. CERTIF. NUMBER:		<input type="checkbox"/> MODIFICATION OF THE PREVIOUS JOB WITH THE SAME EMPLOYER	
VOC. REHAB. COUNSELOR'S FIRM / AGENCY NAME:		<input type="checkbox"/> A NEW JOB WITH THE SAME EMPLOYER	
		<input type="checkbox"/> A JOB WITH A NEW EMPLOYER	
		<input type="checkbox"/> A PERIOD OF FORMAL RETRAINING DESIGNED TO LEAD TO EMPLOYMENT IN ANOTHER CAREER FIELD	
		<input type="checkbox"/> OTHER _____	
STREET ADDRESS:			
CITY, STATE, ZIP CODE:		DATE PLAN WRITTEN:	
TELEPHONE NUMBER:		TYPE OF PLAN SUBMISSION:	
		<input type="checkbox"/> ORIGINAL <input type="checkbox"/> AMENDED	

SECTION II - VOCATIONAL INFORMATION

TYPE OF VOCATIONAL REHAB. PLAN:	<input type="checkbox"/> JOB PLACEMENT <input type="checkbox"/> O.J.T <input type="checkbox"/> FORMAL RETRAINING <input type="checkbox"/> OTHER _____	
PROPOSED SPECIFIC VOCATIONAL GOAL (INCLUDE D.O.T. CODE):		
PROPOSED DEGREE AND PROGRAM OF STUDY (OR MAJOR), IF FORMAL RETRAINING PLAN:		
PROPOSED TRAINING FACILITY:		
STREET ADDRESS:		
CITY, STATE, ZIP CODE:		
SCHOOL / PROGRAM CONTACT:		PHONE:
DIAGNOSED DISABILITY:		
CLAIMANT'S PHYSICAL RESTRICTIONS / LIMITATIONS:		

SECTION III - PLAN JUSTIFICATION

VOCATIONAL REHABILITATION COUNSELOR: CLEARLY STATE WHY THE EMPLOYEE REQUIRES VOCATIONAL REHABILITATION, HOW THE SPECIFIC VOCATIONAL GOAL WAS CHOSEN, HOW THE PROPOSED SPECIFIC VOCATIONAL GOAL WILL ENABLE THE EMPLOYEE TO RETURN TO SUITABLE EMPLOYMENT, ETC. **BE SURE TO INDICATE WHY NO LOWER PRIORITY CAN EFFECTIVELY RESTORE THE EMPLOYEE TO SUITABLE EMPLOYMENT.** PLEASE SUBMIT COPIES OF ANY VOCATIONAL EVALUATION SUMMARY REPORTS, PSYCHOMETRIC TESTING RESULTS, ETC. USED IN THE DEVELOPMENT AND SUPPORT OF THIS PROPOSED VOCATIONAL REHABILITATION PLAN. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET.

SECTION IV - BILLING INFORMATION

PROPOSED STARTING DATE: _____	ESTIMATED COMPLETION DATE: _____
TUITION & FEES \$ _____ AUTHORIZE TO: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
REQUIRED BOOKS \$ _____ AUTHORIZE TO: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
GENERAL SUPPLIES \$ _____ (LIMITED TO \$15.00 / TERM, INCLUDING ONE SUMMER SESSION / YEAR) AUTHORIZE TO: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
ROOM & BOARD \$ _____ AUTHORIZE TO: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
REQUIRED SUPPLIES, TOOLS, OR EQUIPMENT \$ _____ (SUPPLY ITEMIZED LIST & OBTAIN PRIOR APPROVAL) AUTHORIZE TO: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	

SECTION V - TRANSPORTATION, BOARD, AND LODGING INFORMATION

	MILEAGE REIMBURSEMENT REQUESTED AT THE APPROVED RATE FOR THIS TRAINING PLAN. USING THE MOST DIRECT ROUTE FROM THE EMPLOYEE'S RESIDENCE TO THE TRAINING FACILITY, HOW MANY ONE-WAY MILES MUST BE TRAVELLED? _____ MILES.
	THE EMPLOYEE IS REQUIRED TO RESIDE AT OR NEAR THE TRAINING FACILITY. ROOM AND BOARD ARE AVAILABLE AND WILL BE UTILIZED BY THE CLAIMANT. ROOM AND BOARD WILL BE PAID DIRECTLY TO THE TRAINING FACILITY OR INSTITUTION. LOCAL OR COMMUTING MILEAGE IS NOT REIMBURSABLE.
	THE EMPLOYEE IS REQUIRED TO RESIDE AT OR NEAR THE TRAINING FACILITY AWAY FROM HIS / HER CUSTOMARY RESIDENCE. ROOM AND BOARD ARE AVAILABLE, BUT THE EMPLOYEE HAS ELECTED TO RESIDE IN OFF-CAMPUS HOUSING NEAR THE FACILITY, AWAY FROM HIS / HER CUSTOMARY RESIDENCE. CLAIMANT IS REQUESTING THAT THE EQUIVALENT COST OF ON-CAMPUS ROOM AND BOARD BE PAID DIRECTLY TO HIM / HER. LOCAL OR COMMUTING MILEAGE IS NOT REIMBURSABLE.
	MILEAGE REIMBURSEMENT, AT THE APPROVED RATE, IS REQUESTED FOR THIS JOB PLACEMENT PLAN. MAXIMUM REIMBURSEMENT ALLOWED IS 345 MILES PER WEEK.
	OTHER (E.G., MAINTENANCE GRANT RECOMMENDATION, ETC.):

SECTION VI - REMARKS / CONTINUATION

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STATEMENT OF VOCATIONAL REHABILITATION COUNSELOR RESPONSIBILITY: The vocational rehabilitation counselor certifies that this is an appropriate form of vocational rehabilitation. The vocational rehabilitation counselor further certifies that he / she has reviewed the priorities specified in Section 48-162.01 and that no lesser priority can be used to restore this employee to suitable employment.

VOCATIONAL REHABILITATION COUNSELOR SIGNATURE	DATE
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STATEMENT OF EMPLOYEE RESPONSIBILITY: The employee certifies that he / she has reviewed this vocational rehabilitation plan, agrees with the specific vocational goal and the proposed means to attain that vocational goal. The employee further certifies that it is his / her responsibility to cooperate with all parties involved in this vocational rehabilitation plan. The employee agrees to make a good faith effort to participate in and successfully complete this proposed vocational rehabilitation plan.

EMPLOYEE SIGNATURE	DATE
--------------------	------

STATEMENT OF EMPLOYER / INSURER RESPONSIBILITY: The employer / insurer understands its responsibility to pay and agrees to pay temporary benefits while the employee is participating in and making satisfactory progress toward completing this vocational rehabilitation plan.

EMPLOYER / INSURER SIGNATURE	DATE
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STATEMENT OF WORKERS' COMPENSATION COURT REHABILITATION SPECIALIST RESPONSIBILITY: The Workers' Compensation Court Rehabilitation Specialist certifies that he / she has reviewed this plan and approves / denies this plan as an appropriate form of vocational rehabilitation necessary to restore the employee to suitable employment.

PROPOSED VOCATIONAL REHABILITATION PLAN IS:	<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
WORKERS' COMPENSATION COURT REHABILITATION SPECIALIST SIGNATURE		DATE